Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150047	A. BUILDING _____ B. WING _____	01/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOSPITAL	700 BROADWAY FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of one hospital licensure complaint. Complaint Number: IN00100742: Substantiated: No Deficiencies Cited Date: 1/3/12 Facility Number: 005043 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor St. Joseph Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Services and 410 IAC 15-1.6.2, Emergency Services, Indiana Hospital Licensure Rules. QA: claughlin 01/05/12	S 000		